Requesting a Medical Record from the St Louis City Division of Corrections

Under state statute RSMO 109.255 the Division of Corrections does maintain inmate medical records for 10 years. If you are requesting medical records for yourself or have been designated by a former inmate please fill out and send in a HIPAA (Health Insurance Portability and Accountability Act) linked to these directions. The form needs to be completely filled out and then sent to the following address:

ATTN: Custodian of Records
City of St Louis Division of Corrections
St Louis City Justice Center
200 South Tucker Blvd
St Louis MO 63102

Records will be sent out as soon as possible, but depending on staffing, age of records, and work load it can take up to 30 days. Records will be sent in paper format and cannot be emailed or faxed to an individual or agency.

Also, under RSMO 191.227 the Division of Corrections can charge up to $25.34 for the record and $.58 per page. Once a record is invoiced all checks or money orders for the record will need to be made out to the City of St Louis.

Thank you

Directions

Please read and fill out this form (front and back) making sure to include address and phone number on the front and signature with date on the back of the form.

Once the form is complete please return to the St Louis City Division of Corrections at the address on the back or by dropping the form off at the City Justice Center.

The Records Unit will try to get the records to you as soon as possible, but depending on the request it could take 30 days to have the records available.

Finally, to aid in reentry the St Louis City Division of Corrections can provide a copy of records to former inmates free of charge, but we will charge for additional copies and copies sent to legal representatives in accordance with state statute (RSMO 191.227).

Department of Public Safety/Division of Corrections

HIPAA COMPLAINT

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FORM

Patient Name_____

Patient Date of Birth_____ Patient SS#_____
(Optional)

I _____hereby authorize
(Patient or Personal Representative)

_____**St Louis City Division of Corrections**_____to disclose specific health information from the records of the above named patient to:

_____
(Recipient's Name/Address/Phone/Fax)

_____

_____

for the specific purpose(s): _____

_____

Specific information to be disclosed: _____

_____

I understand that I may revoke this authorization at any time. If I want to revoke this authorization, I have to do it in writing and send it to the above specific Recipient who is authorized to receive the health information and/or to the persons who are authorized to disclose the health information under this authorization form. My revocation of this authorization, though, will not apply to any information that has

already been disclosed before I've effectively revoked this authorization. Also, my revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date or event:

_____

_____

If I fail to specify an expiration date or event, this authorization will expire in six (6) months.

I understand that any information disclosed under this authorization to above stated Recipient might not be protected by the state or federal confidentiality or privacy laws or rules and could be re-disclosed by Recipient.
I understand that if my record contains information relating to HIV infections, AIDS or AIDS-related conditions, alcohol abuse, or behavioral or mental health services, this disclosure will include that information.

I also understand that I may refuse to sign this authorization. My refusal to sign an authorization will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if treatment is researched-related, treatment may be denied if authorization to a health care provider of such treatment is not given.

A photo-static copy of this authorization may be used in place of an original.

_____ _____

(Signature of Patient or Personal Representative) ***(Date)***

_____

(Print name of patient or Personal Representative)

_____

(If signed by Personal Representative, provide description of personal Representative's authority to act for patient and attach copies of documents in support of that authority).

Forward all requests to:

ATTN: Custodian of Records
City of St. Louis Division of Corrections
St. Louis City Justice Center
200 S. Tucker Blvd.
St. Louis, MO 63102

Phone # (314) 621-5848
Fax (314) 588-0273